DEPARTMENT OF MANAGED HEALTH CARE

PROPOSED ADOPTION OF TITLE 28, CALIFORNIA CODE OF REGULATIONS
DIVISION 1. THE DEPARTMENT OF MANAGED HEALTH CARE
CHAPTER 2. HEALTH CARE SERVICE PLANS
ARTICLE 2.5 DISCOUNT HEALTH PLANS
SECTIONS 1300.49.1.1-1300.49.1.12, AND
ARTICLE 3 PLAN APPLICATION AND AMENDMENTS
SECTION 1300.51.01

FINAL STATEMENT OF REASONS

DISCOUNT HEALTH PLANS

(2001-0024)

As required by section 11346.9 of the Government Code, the Department of Managed Health Care (Department) provides below the required update to the information set forth in the Initial Statement of Reasons, including the reasons for the final revisions made to the regulation text as initially published in this rulemaking action proposing the adoption of Article 2.5, sections 1300.49.1.1 through 1300.49.1.12 and amendment of Article 3, adding section 1300.51.01, to Title 28 of the California Code of Regulations.

Necessity

The Department is responsible for the oversight of a discount health plan if that entity meets the definition in Health and Safety Code section 1345(f)(1). That section defines a health care service plan as: "Any person who undertakes to arrange for the provision of health care services to subscribers or enrollees, or to pay for or to reimburse any part of the cost for those services, in return for a prepaid or periodic charge paid by or on behalf of the subscribers or enrollees." Currently, discount health plans are evaluated as to whether they meet the definition in 1345(f) on a case-by-case basis, which is time consuming and costly. The proposed regulations are necessary to clarify and streamline the licensing and operational process for discount health plans that are required to follow the Knox-Keene Health Care Service Plan Act of 1975[1] ("Knox-Keene Act").

The Department has received hundreds of consumer complaints and inquiries regarding discount plans since 2003, when the Department began tracking consumer comments regarding discount plans. An increasing number of discount health plans are operating in California, and so more consumers are affected by the actions of discount health plans. To date, only a few discount health plans have obtained licenses under the Knox-Keene Act. Several applications for licenses are under consideration by the Department, necessitating the need for clarification regarding discount health care service plan licensure and operational requirements.

[1] California Health and Safety Code section 1340 et seq.

The Department has determined that the adoption of these regulations is necessary in order to clarify and make specific the licensing and operational requirements for discount health care service plans that are subject to the Knox-Keene Act, and to protect the consumers and subscribers who purchase these products.

UPDATED SPECIFIC PURPOSE OF THE REGULATION

The purpose of the regulation remains the same as stated in the initial statement of reasons, with the following additions to the originally noticed regulation text. The amendments to the proposed regulation:

- Clarify that discount programs offered free of charge are not subject to the regulation.
- Expand the definition of "value added services" to include rewards for participation in programs that encourage wellness.
- Add a requirement that any entity claiming an exemption from the regulations must notify the Department in writing.
- Clarify that a discount program offered at no additional charge to members of an affiliated automobile club, that meets certain conditions, is not subject to the regulation.
- Add a requirement that any consumer who enrolls in a discount product over the phone must be mailed copies of the evidence of coverage and membership card within three business days. The enrollee may elect to receive electronic or faxed versions of these documents instead.
- Clarify a requirement that if a plan's network provider refuses to bill an enrollee at the discounted rate, the discount plan will pay the enrollee the difference so that the consumer obtains the benefit that was promised to them by the discount plan.
- Exempt discount health plans from the recently enacted timely access standards (28 CCR section 1300.67.2.2) that are imposed on non-discount health plans, except that a discount health plan's consumer call center must answer calls within ten minutes.
- Add examples of how discount health plans must evaluate the language assistance needs of their enrollees.
- Add a requirement that discount health plans must provide translations of certain written documents.

Regarding specific final revisions made to the proposed regulation text for Sections that were initially published for public comment on January 8, 2010:

1300.49.1.1 Definitions

The definition of "discount health product," subsection (c), was amended to clarify that a discount card that is available at no charge is not subject to the regulation. This change was the result of public comment that requested clarification regarding the applicability of the regulations to those products, and is necessary for clarity.

The definition of the term "value added services," subsection (g), has been updated to include rewards related to wellness rewards programs. The expansion of the definition is necessary to clarify that rewards are among the products that are not subject to the regulation.

1300.49.1.2 Licensing

Subsection (g) was amended to clarify the use of the term "program" within the section.

Subsections (g) and (h) were amended to require that an entity that claims a specific exemption notify the Department in writing. This requirement is similar to that found in 28 CCR section 1300.43.10(n), which requires that any entity claiming an exemption for nonprofit retiree plans notify the Department in writing. The section also requires notification of any material change that could affect the entity's eligibility for the exemption. The section is necessary so that the Department, and the public, has notice that an entity is claiming an exemption, or may no longer be eligible for an exemption.

Subsection (i) was introduced and amended based on public comment. This section is necessary to clarify that a certain type of discount product, offered to members of an affiliated automobile club at no additional charge, and subject to certain conditions, is not subject to the regulation.

1300.49.1.3 Marketing of Discount Health Plan Contracts

Subsections (a), (f), and (g) were amended to use the word "product" rather than "plan" where appropriate for consistency with the definitions in proposed section 1300.49.1.1. This change was developed based on public comment and is necessary for consistency throughout the regulation.

Subsection (c)(4) was added to require that discount health plans and solicitors provide a written follow up to any telephone enrollment transactions. This change is in response to public comment. The proposed change requires that the plan send membership materials, including the evidence of coverage, within three business days of the telephone enrollment. This time frame is necessary to allow the consumer adequate time during the 30-day penalty-free cancellation period to consider whether they will cancel their membership without penalty, other than the administrative fee of up to $30. The requirement is comparable to Insurance Code section 762 (c)(3), which requires that any

telephone sale of an insurance product or annuity be followed by written disclosure by mail within three business days.

1300.49.1.4 Requirements Regarding Discounts/Demonstrating Bona Fide Discounts

Subsection (b) was amended to correct a typographical error and to use the word "product" rather than "plan" where appropriate for consistency with the definitions in proposed section 1300.49.1.1. This change was developed based on public comment and is necessary for consistency throughout the regulation.

Subsection (d) was amended to clarify the process when an enrollee is denied the discount promised by the plan. The clarification of this section is in response to public comment and is necessary to clarify the plan's obligation to make the consumer whole if the consumer obtains services from a provider that is represented by the plan to be in the network, and that provider does not bill at the discounted rate promised by the plan.

1300.49.1.5 Availability and Accessibility of Discounted Provider Services

Subsection (a) was amended to create an exemption to the recently enacted timely access regulation (28 CCR section 1300.67.2.2) that is necessary because of the business and limited operational structure of discount health plans, and to preserve the affordability of these programs for consumers. Discount plans do not oversee the utilization or management of care as do non-discount plans, and are not notified regarding the outcome of any provider visits, and so most of the timely access requirements are not consistent with the appropriate level of oversight of a discount plan. Subsection (a)(6) was amended to be consistent with the timely access regulation because discount plans are already required to have an administrative call center within the structure of the plan, and so compliance with this requirement of the timely access regulation is appropriate.

1300.49.1.6 Grievance Systems

No proposed changes.

1300.49.1.7 Cancellation and Termination

No proposed changes.

1300.49.1.8 Language Assistance

Subsection (b) was amended to clarify the types of data the discount plan must consider when assessing linguistic needs. The examples are similar to those found in Health and Safety Code section 1367.04, and the Department's language assistance regulation, 28 CCR section 1300.67.2.2. This change was made in response to public comment that indicated that the plan's obligation to provide language assistance required some level of assessment of those needs, without creating an undue burden on the plan. This section is necessary to ensure that enrollees obtain appropriate language assistance from the discount plan.

Subsection (b)(ii) was added to require translation of vital documents. This change is the result of several public comments that expressed concerns that no written plan documents were required to be available in any language other than English. This requirement is also similar to Civil Code section 1632, which requires that, for several types of financial contracts, any person who negotiates a contract in one of the five most common non-English languages must provide a written contract in that language. The proposed changes are also similar to Health and Safety Code section 1367.04, and Department's language assistance regulation, but were tailored to include only those documents applicable to the discount plan business model. This section is necessary to ensure that enrollees who require language assistance can understand, at a minimum, those documents that are disclosures of basic rights and responsibilities in their contract with the discount plan.

1300.49.1.9 Financial and Administrative Requirements

No proposed changes.

1300.49.1.10 Subscriber and Enrollee Disclosure Forms

Subsections (b) and (e) were amended for consistency of the use of the terminology from the "definition" section-the use of "discount health plan" and "discount health product." This change is the result of public comment, and is necessary for consistency with section 1300.49.1.1.

1300.49.1.11 Subscriber Contracts

No proposed changes.

1300.49.1.12 Provider Contracts

No proposed changes.

UPDATE TO DOCUMENTS CONSIDERED

Aside from the public comments that are incorporated in the rulemaking record, no additional documents were considered.

REASONABLE ALTERNATIVES TO THE REGULATION

Through the public comments submitted during the rulemaking process, including comments submitted during informal public comment periods and public hearings, many different alternative approaches and text were presented to and considered by the Department. The public comments and the Department's responses to each are contained in the rulemaking file and are incorporated herein by reference.